of advanced tuberculosis in which, upon arrival here, this heart weakness, together with the greatly diminished lung area, caused acute suffering, demanding immediate return to a more favorable elevation. This may be advised the more readily because no possible climatic advantages can be of any service to such patients. The atrophic heart of wasting disease, the decreased lung area, the anemia, the general weakness, the exertion of coughing, and the mental anxiety, are all doubtless contributory factors.

In fairly compensated valvular lesions I have seen death follow a sudden break in the compensation from a single severe overexertion. The same factors which operate upon the arteriosclerotic heart are active also in these cases, as well as the greater demands which given work makes upon this organ, the liability to overexertion because of the stimulating climate, etc. A typical example is that of a boy, aged eighteen years, with well-compensated aortic regurgitation following rheumatism. He was quite an athlete in the early days of wheel riding, and rode one day with this club to a point twenty miles away in the foothills. This he did quite easily, but it evidently was all that he should have done that day. On returning in the afternoon he found that a stiff head wind had arisen, and with all the exertion he could make he was not able to keep up with his companions. He went to bed on reaching Denver, and presented, when I examined him, a greatly dilated heart, mitral regurgitation, general anasarca, albuminuria, and all the signs of imminent death from acute cardiac failure. His death was reported to me by his physician a few days later.

A long experience here convinces me, however, that the average case of well-compensated valvular disease does as well here as anywhere else. The relative infrequency of acute rheumatism as compared with some harsher climates, is advantageous. Those acclimated and well accustomed to the seasonal and topographical peculiarities of a mountainous region, are not so likely to fall into the errors I have noted as newcomers would be.

Patients with valvular disease, but with well-nourished heart muscle and fair arteries, may, almost regardless of age, I believe, go to reasonably high altitudes with safety, if only they follow the rule I have long laid down for my cardiac patients, namely, to make no exertion which causes any considerable dyspnœa. After any failure of compensation occurs it is better to avoid the increased demands involved.

THROMBOSIS OF THE INFERIOR VENA CAVA.

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THE value of reports of unusual cases lies, first, in the clinical interest and attention aroused by anything out of the ordinary, and, second, in the educational value of this attention if it is pursued to a logical conclusion. A report of two cases of thrombosis of the inferior vena cava, therefore, should prove of some interest, particularly if it includes a study of the manifold clinical manifestations of the condition. This communication concerns two such cases, Case I being acute and possibly a sequel of influenza, and Case II being chronic, the diagnosis being made possible by the collateral circulation.

CASE I.—A man, aged twenty-six years, single, a clothing salesman by occupation. His personal history is uneventful, with the exception of typhoid fever four years previously, from which he made a good recovery. He has noticed a gradual gain in weight the past few months. Two weeks before the onset of the present illness the patient was confined to his bed a few days with influenza, but after three or four days he was able to be about and returned to work. He felt well for a week, but at the end of this time, while lifting a heavy case of dry goods, he was seized with a severe pain in the right side. On examination his physician found his abdomen tender, with some ascites, and diagnosticated probable cirrhosis of the liver.

When seen by E. R. S., five days later, the man seemed desperately ill; his face was drawn, anxious, and very pale, but he was able to talk intelligently with a very weak voice. On examination he appeared to be rather well-built and muscular. His heart and lungs were negative. There was no fever. The abdomen was enormously distended, tense, symmetrical, and tympanitic on percussion, with slight tenderness. The liver and splenic dulness were not demonstrable. No fluid in the abdominal cavity could be discovered on account of the tympanites. The legs and external genitalia were much swollen, œdematous, and cyanosed, but not tender or painful, except for the tenseness and tightness due to the œdema. The history of the swelling was that it had come on gradually since the onset of his illness. Rectal examination was negative. The bowels moved regularly. The urine on examination was free from albumin, and in other respects negative.

The appearance of the abdomen suggested an intestinal obstruction or paresis with tympanites, due to some subacute inflammatory exudate in the pelvis obstructing the iliac veins, or a possible neoplasm or a tuberculous peritonitis.

An exploratory operation was advised, but was refused. At this time the superficial veins were not noticeably prominent. The patient lived about three weeks and died of exhaustion.

The autopsy, made twelve hours ofter death, revealed the following important findings:

The lungs were negative, with the exception of a few adhesions at the left apex and a few small infarcts. The heart was normal. The legs and genitals were swollen and œdematous, but no distended veins were noticeable on the legs or abdomen. The left arm was also œdematous and swollen up to the mid portion of the humerus. On opening the abdomen the abdominal fat was found atrophied and the abdominal wall was 1 cm. in thickness. A large amount of embalming fluid, somewhat blood-stained, escaped. There were no adhesions between the coils of intestines and the parietal peritoneum. The spleen was much enlarged and very hard. The liver measured 25 x 20 x 10 cm.; the surface was smooth. The left lobe was much larger than the right, measuring 12 x 15, while the right measured 17 x 12 cm. The left lobe occupied almost the position normally occupied by the right, that is, the midline. The right lobe was pushed to the right and turned backward, bringing the gall-bladder well under the costal margin in the axillary line. The consistency of the liver was normal, and on section there was considerable passive congestion. The gall-bladder, œsophagus, stomach, pancreas, and adrenals were normal. The inferior vena cava, found to the right of the aorta, was widely dilated, thrombosed, and solid; on section it was found to contain a partially organized blood clot, which extended downward into both common iliac veins and upward to the groove in the posterior surface of the liver, where, near the upper surface of the liver, it ended. The walls were much thickened, fused together, and firmly adherent; the lumen was obliterated. The vessel above that was collapsed and empty. The hepatic and renal veins were also blocked by thrombi continuous with that in the vena cava. The portal system was not obstructed. The anatomical diagnosis was: Œdema of both legs and left arm; dilatation of the superficial veins above the costal margin; œdema of the genitals; thrombosis of the inferior vena cava, renal, and hepatic veins; ascites; multiple infarction of the left lung; adhesive pleuritis of the left apex; chronic passive congestion of the spleen and liver; rotation of the liver to the right and enlargement of the left lobe; peptic ulcer of the duodenum.

On reconsideration of the case two possible causes of the thrombosis are prominent: (1) Influenza may have been the primary cause, and the thrombosis may have been due to a secondary influenzal thrombophlebitis with extension into the inferior vena cava. This disease is not infrequently associated with thrombosis. Leyden and Guttman have collected twenty-eight cases of thrombosis of the large veins occurring in the epidemic of 1889 and 1890, and thrombosis of the smaller veins is quite common in the disease. On the other hand, the strain of lifting may have caused the tilting over to the right of the liver, causing a twist of the vena cava which mechanically caused a thrombosis. If so this case is unique, the only case approaching it being one reported by Jobert,[1] in which a soldier, after a severe and exhausting march, was suddenly seized with swelling of both legs and the abdomen. He improved after four weeks, but five years later showed the development of a collateral circulation typical for thrombosis of the inferior vena cava.

CASE II.—E. W., aged forty-two years, unmarried, an orderly. The chief complaint was swelling and ulceration of the legs. The patient has never been seriously ill. He denies venereal infection. There has been no history of digestive disorders or disturbances of the central nervous system. He has never been short of breath and there has been no swelling of the feet or ankles. The urinary functions have been normal. He states that from twenty-one years of age he was employed as a bartender and used alcohol to excess, and at that time was using tobacco freely, smoking ten to fifteen cigars daily. Coincident with this overindulgence in alcohol he began to have attacks of chills and fever, lasting two or three days. At first these attacks occurred once a year, but later with greater frequency, until finally they came once in three weeks.

The present illness began in 1893. The onset was sudden, with a severe pain in the calf of the left leg, sharp and sticking in character. The patient was in apparent good health at the time and was sitting in a chair at rest. The pain was so great he was unable to bear his weight on the foot and went to bed. On the following morning the leg was still very painful and greatly swollen as far as the knee. The second morning on arising, the right leg was affected in a similar way; the pain, however, was not localized, but affected the whole leg, which began to swell immediately. The swelling began in the toes and extended upward, until at the end of ten days the whole leg was swollen. The leg became black at first, but gradually the natural color returned. About three weeks afterward an attack of pleurisy suddenly developed on the left side, which, with the swelling in the legs, kept him in bed three months. At the end of this time ulcers formed on both legs and have been present ever since, almost healing at times and then breaking down again. His general condition, however, has slowly improved, and he has been able to be up and about and to do light work.

The attacks of chills and fever have been more frequent since the onset of his present illness. During these attacks the temperature rises to 102° or 103°, and is accompanied by a shaking chill, headache, and nausea. The attack is generally over in twenty-four hours. On March 26 the patient fell while walking, and strained his left side in the loin. Shortly after this the legs increased in size and he began to have a septic temperature, with daily elevations of 102° to 103°. He is at present confined to his bed.

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[1] Gaz. hebd., 1871, viii.

The patient is a stout well-built man, pale, and anemic. The heart and lungs are normal. The arteries are not thickened. The lower border of the liver is not palpable, but on percussion the dulness extends 10 cm. below the costal margin in the mammary line. The spleen is not palpable, and by percussion does not appear to be enlarged. The abdomen is symmetrical and slightly distended, but no masses can be felt. The superficial veins are distended on the left side, being tortuous, elevated above the surface, and easily palpable (Figs. 1 and 2). The veins are also enlarged in the left groin and extend upward, and, gradually diminishing in size, communicate with the terminal branches of the internal mammary vein. When compressed they fill from below. The deep epigastric and superficial circumflex iliac veins form a compensatory circulation with the deep epigastric and lumbar veins above. The veins on the right side of the abdomen are also dilated, but to a lesser degree. They can be distinctly seen running tortuously beneath the skin, but are not easily palpable. It is impossible to determine whether the veins are dilated in the right groin or not, due to the great swelling and induration of the leg.

The left leg is swollen to the level of the knee, the skin is tense, and on palpation the tissues are indurated and hard. In the middle portion of the leg are scars of former ulcers, and an ulcer of small dimensions is there now. The right leg is swollen to the level of Poupart's ligament and is about twice its normal size. The skin is tense and firm, and there has been a proliferation of the connective tissue, giving rise to a condition of elephantiasis. Below the knee there is an ulcer discharging a purulent material and scars of former ulcers. At Poupart's ligament is a deep depression, the result of an operation to relieve pressure on the femoral vein, which it was supposed might be the cause of the obstruction to the venous return flow.

The scrotum and penis are not swollen, and rectal examination shows no masses or anything which could cause obstruction to the return of the venous blood from the legs. Hemorrhoids are present, but give no symptoms.

A blood culture, made during one of the attacks of chills and fever, remained sterile. Repeated examinations of the blood for malarial parasites were negative.

In this case the important points are that the patient, in apparently good health, suffered a sudden stoppage of the veins of the left leg below the knee, and on the second day following a stoppage of the veins of his right leg. This caused both legs to swell: the left to the knee, the right to the groin. Subsequently a condition of elephantiasis developed with crural ulcers, and later the veins on the left side of the abdomen became dilated and tortuous.

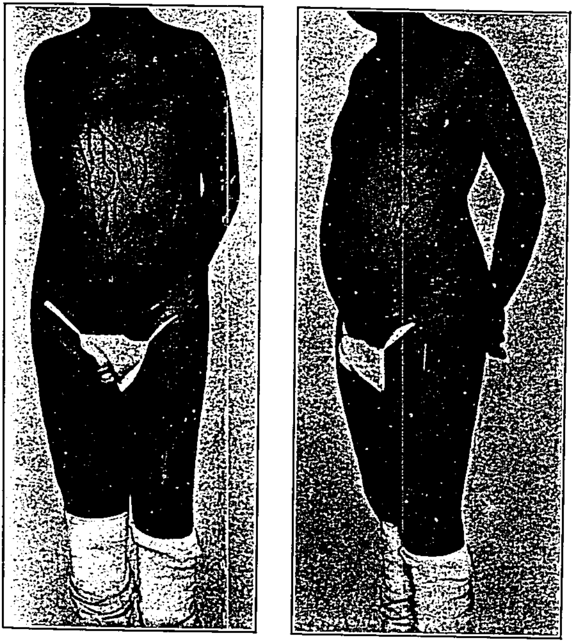

FIG. 1 FIG. 2

Case II, showing the collateral circulation on the right side and front of the abdomen, with elephantiasis of the right leg to the groin and of the left leg to the knee.

It is fairly clear that the obstruction in the left leg was due to a thrombus. Whether this thrombus, by extension through the iliac vein into the lower vena cava, obstructed the right common iliac vein, or whether two distinct thrombi formed, one in each leg, is an open question. We are inclined to believe this latter supposition is the correct one, in view of the fact that the compensatory circulation on the left side did not develop at once, but gradually. Assuming that at the outset there was a thrombus on both sides, in the popliteal on the left and the femoral on the right, we believe that the thrombus extended upward until at the present time it obstructs the lower part of the inferior vena cava, since otherwise there is no explanation for the establishment of the compensatory circulation between the left deep epigastric and internal mammary veins, between the hemorrhoidal veins and the portal circulation, and between the deep epigastric, lumbar, ascending lumbar, and azygos veins. The thrombus has not yet reached the level of the right spermatic vein, which empties into the inferior vena cava below the renal vein, and which, if obstructed, would cause a swelling of the scrotum.

The attack of pleurisy which occurred three weeks after the onset of the present illness can be explained by assuming that a small portion of the clot became dislodged and led to infarction of the lung, with a slight exudation on the pleural surface. The periodical attacks of chills and fever are more difficult of explanation, but, so far as can be determined, they must be due to a general infection, with periods of latency. The source and nature of the infection we have not been able to determine.

On perusal of the literature of thrombosis of the inferior vena cava, we find that the condition is not common. Krauss,[2] in 1894, was able to collect 102 authentic cases, and Welch[3] says there are more than 140 cases on record. On the other hand, the condition appears to be not uncommon in statistics of large hospitals; presumably most of the cases receive no attention in periodic literature.

Thrombosis of bloodvessels is primarily associated with a combination of circumstances, in which three conditions stand out prominently: (1) Changes in the chemistry of the blood. These are rather indefinite and refer to certain changes in the composition of the blood, either in proteins,. fibrin ferment, or antiferment, whereby the blood is made more coagulable. (2) Mechanical factors, in which a weak heart muscle and sluggish circulation play the most important part. (3) Most important of all, some injury or degenerative change in the endothelium of the bloodvessels which determines the formation of a coagulum at this point. This injury may be mechanical or may be due to the action of bacteria or their toxins. In thrombosis of the inferior vena cava the thrombus is rarely autochthonic, but usually reaches the vena cava by extension from the femoral or pelvic veins through the iliac veins, or it is associated with intra-abdominal growth. In Krause's series of 89 cases, in which the cause of the association of the thrombosis was investigated, he found: 25 cases in which the thrombus was associated with malignant growths within the abdomen; 11 cases belonged to the group of marantic thrombi; 8 cases were caused by compression from without; 8 cases were traumatic; 8 cases were associated with puerperal conditions; 7 cases were secondary to phlegmasia alba dolens, ulcus cruris, etc.; 7 were cases of organized thrombosis, mostly marantic; 4 were cases of compression occlusion without thrombosis; and 9 were cases of thrombophlebitis. Malignant growths of the abdomen furnish the largest number of cases. The greater proportion of these affect the inferior vena cava by direct extension into the tissues about the vein, and 80 per cent. perforate directly into it. The primary situation of the growth is apparently of little consequence in determining the likelihood of thrombosis. Carcinoma of the kidney furnishes the largest number of cases; uterine cancer, cancer of the testes, of the liver, of the penis, or new-growths of the retroperitoneal tissues furnish examples of extension into the vein. One case of primary sarcoma of the vein is on record and one case of endothelioma.

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[2] Ueber Verschluss der Vena cava superior und der Vena cava inferior. Tübingen, 1894.

[3] Allbutt's System of Medicine, vi, 217.

The group of marantic thrombi is interesting. The name was first applied by Virchow to the thromboses commonly associated with anemic and cachectic states, and was supposed to be due to sluggish circulation, as well as to certain ill-defined changes in the blood. This view, however, has undergone some revision, since recent studies have shown that many of these so-called marantic thrombi contain the microörganisms of the primary disease with which they are associated. Many of them, therefore, should be classed with the group of infective phlebitis. Phthisis furnishes the largest number of instances of complicating thrombosis of the inferior vena cava, while typhoid fever, erysipelas, cancer of the stomach, influenza, and pneumonia may be the primary diseases.

Compression of the vena cava from without may cause occlusion of the vessel with or without the formation of a thrombus. It is of interest to note in this connection that in one case a pregnant uterus, in one a uterine fibroid, and in one case an ovarian cyst was the primary cause. Retroperitoneal growths, aneurysm of the abdominal aorta, syphilis of the liver, and hypertrophy of the head of the pancreas have all caused such pressure occlusion.

Thrombophlebitis of the inferior vena cava occurred but nine times. One case was caused by perforation of the vein by a needle that had been swallowed and migrated until it penetrated the vein; one case was caused by an extension upward from a thrombophlebitis of the uterine veins caused by a pessary; one case followed a urethral blenorrhœa.

Reviewing, then, the etiology, we find that thrombosis of the inferior vena cava is usually associated with malignant growths of the abdomen, with certain infectious diseases, with septic conditions, and with trauma.

Symptoms. In considering the symptoms of the thromboses, we can conveniently divide the cases into three varieties: (1) Cases in marantic and cachectic individuals in whom autopsy reveals an antemortem thrombosis of the inferior vena cava, but in whom there were no symptoms during life to call attention to the condition. (2) Cases of partial thrombosis, or of very slowly developing thrombosis. In this interesting group fall those cases of thrombosis of the vena cava in which no symptoms reveal themselves; and it is not until the establishment of the collateral circulation or autopsy that the diagnosis can be made. The most famous case in this second group is that of Quincke,[3] in which, postmortem, the vena cava was found obliterated. During life there was no cyanosis, no œdema of the legs or abdomen, no dilated superficial veins in evidence, and even at the autopsy no definite collateral circulation could be demonstrated. Another interesting case was reported by Warred,[4] in which the inferior vena cava was congenitally thrombosed. Betz[5] reported the case of a male, aged twenty-one years, suddenly dead of acute abdominal disorder, in which the inferior vena cava was found thrombosed with the establishment of a compensatory collateral circulation. The occlusion of the vein was considered to have been congenital. (3) In the third group fall the greater number of cases in which definite evidence of obstruction is present and in which the diagnosis can be made with reasonable confidence. As early as 1840 Rennart, and in 1860 B. Cohn, endeavored by experimental occlusion of the inferior vena cava in dogs to study the effect of such occlusions on the circulation. Their results, however, were so inconstant and inconclusive that the experiments were abandoned. We must, then, be satisfied with the studies of case reports and make allowances for the variations and inconsistencies of the symptoms.

Pain is a rather constant symptom. Its location, as well as the severity varies. Since the circulatory effect of the thrombosis is first manifested in the legs, pain in the legs is most frequently noted; next in order of frequency in the lower abdomen. On the other hand, some patients complain of no particular pain, except the soreness and tenseness due to the œdema and distention. A. Robin regarded pain in the lumbar region with prostration and tenderness about the navel as rather characteristic of thrombosis of the inferior vena cava. On the whole, pain is of little value in the diagnosis. It was mentioned occurring in the legs fifteen times, and in the abdomen sixteen times in Krause's series.

Objectively the most important symptom is œdema of the legs, genitalia, etc., in the region drained by the inferior vena cava. The development of this œdema depends upon the suddenness and degree of closure of the vein, the facility with which the collateral circulation is established, and the condition of the circulatory system of the patient. The œdema is usually bilateral. Schlesinger,[6] on the contrary, was able to collect out of 120 cases 18 in which the swelling was principally one-sided, but in which an autopsy revealed complete closure of the inferior vena cava. The only explanation of this one-sided œdema is either a particularly rich and competent collateral venous circulation, or a possible previous disease of the iliac veins with the previous establishment of a partial collateral circulation. On the other hand, œdema of the legs is not invariably present, as in the case reported by Bresler,[7] who thought that the non-appearance of the œdema was due to the very gradual closure of the vena cava with the rapid development of a competent collateral circulation without the œdema. The œdema extends from the legs and genitals to the abdominal wall, and may in extreme cases extend to the arms, breast, face, etc. General hydrops has been observed five times, and hydrothorax twelve times. Ascites is a rather frequent accompaniment of the condition, depending largely upon the height of the thrombus and the amount of congestion of the viscera. It occurred twenty times in Krause's series. Cyanosis may accompany the œdema, depending upon the rapidity of the occlusion. It was noted by Krause eight times, but seems generally to be considered one of the most constant symptoms of the disease. It occurs particularly in the legs.

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[3] Von Ziemssen's Handbook, vol. vi.

[4] Dublin Medical Journal, lxxv, 36.

[5] Virchow-Kirsch, Jahresbericht, 1877.

Fever is usually present, but depends rather on the primary disease, or on complications, than on the thrombosis. A few cases are on record, however, in which the fever could be explained by the thrombosis. Robin reported a case from the study of which he concluded that a sudden high rise in temperature is rather characteristic of the thrombosis. Fever was specifically mentioned but twenty-eight times in Krause's series.

On the part of the intra-abdominal organs, objective examination reveals rather varied results. The liver may or may not be enlarged. The spleen was enlarged fourteen times. Diarrhœa occurred eighteen times, while constipation was mentioned seven times. Bloody stools occurred once. Albuminuria, regarded by Raymond as constant in thrombosis of the inferior vena cava, occurred but eight times in Krause's series and was absent in the present case. It appears that even when the renal vein is occluded the occurrence of albumin in the urine is not constant.

The most important objective symptom, and the one without which the diagnosis can never be reasonably made, is the evidence of the establishment of the collateral circulation. This means that the venous blood must reach the right auricle by means of the superior instead of the inferior vena cava. There appears to be no general rule that Nature follows to bring this about. Much depends upon the thrombosis and such accidental and congenital disposition of the smaller branches of the veins as most easily to facilitate the conveyance of the blood from one system to the other. The main channels through which this is brought about is by way of the superficial epigastric and superficial circumflex iliac branches of the femoral below, and the long thoracic, a branch of the axillary, in front, and some anastomosing branches of the lumbovertebralis behind. A general idea of the appearance of the collateral circulation may be gained from the photograph of Case II of the present report.

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[6] Zur Diagnostik der Erkrankungen der Vena cava inferior. Deut. med. Woch., 1896, xxii, 460–461.

[7] Deut. med. Woch., 1897, xxiii, 179.

It is self-evident that the prognosis of these cases is necessarily grave and depends on the primary disease with which it is associated. All the cancer cases (25 per cent.) die. Of the marantic thrombi group, nearly all die, associated, as they are, with unusually severe antecedent disease. In the other group, the mortality depends entirely upon the general condition and resistance of the patient and the facility with which the collateral circulation is established. A complication to be feared is pulmonary embolism. The duration of the disease is roughly one or two months. On the other hand, some patients do recover. Bresler reported a case with recovery after typhoid fever. Thompson[8] reported a case that died on the fifty-ninth day. Jobert reported a case that was alive four years after the onset of thrombosis, while Bates reported a case of congenital thrombosis of the inferior vena cava that lived twenty-one years; so that recovery does occasionally occur, although so rarely as to be almost accidental.

COMPLETE AURICULOVENTRICULAR DISSOCIATION WITHOUT SYNCOPAL OR EPILEPTIFORM ATTACKS.

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The earliest recorded observation that I could find of what we may believe was an instance of auriculoventricular dissociation is contained in a paper by Mayo[1] (1838). In this paper is described the case of a man, aged fifty-two years, who suffered from attacks of vertigo and epileptiform seizures and who had a very slow pulse (21 to 34). Mayo noticed that there was a time "when two imperfect actions of the ventricles could be heard between stronger ones which alone were attended with a pulse at the wrist." The next observation is found in Stokes'[2] well-known paper (1846). His patient had a slow pulse (28 to 40) and was afflicted with apoplectiform attacks which were not followed by paralysis. In this case there were pulsations in the right jugular vein, and Stokes noted that these pulsations were more than twice as frequent as "the manifest ventricular contractions."

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[8] Trans. Clin. Soc., vol. viii.

[1] London Med. Gaz., 1838, xxii, 232.

[2] Dublin Quart. Jour. Med. Sci, 1846, ii, 73.

Cases of the same character were recorded by Blondeau[3] in his thesis (1879). Chauveau,[4] in 1885, made the first graphic records of the movements of the heart in auriculoventricular dissociation. It was not until after a number of years had elapsed, and His[5] had reported his case of "heart-block" (1899), that interest in the matter was awakened. From experimental knowledge he inferred that the condition, as found in man, might be due, among other possible causes, to injury to the bundle of muscle fibers which connects auricles to ventricles. This bundle was described by Paladino[6] in 1876, and subsequently by Stanley Kent,[7] His[8] and others.

All of the above instances of heart-block are cases which presented during life the symptom-complex named by Huchard[9] "Adams-Stokes disease," in honor of the two Dublin physicians whom he credited with the original descriptions of the affection. Cases of permanently slow pulse in which certain nervous phenomena appear, such as recurring attacks of vertigo, syncope, and epileptiform or apoplectiform seizures, are found much earlier in the literature. Two typical cases are described at length in Morgagni's[10] "De sedibus

[3] Thèse de Paris, 1879.

[4] De la dissociation du rythme auriculaire et du rythme ventriculaire. Rev. de méd., 1885, 161 (Figuet's case).

[5] Deut. Arch. f. klin. med, 1899, lxiv, 316.

[6] Berl. klin. Woch., 1908, xlv, 861.

[7] Jour. phys., 1893, xiv, 233.

[8] Wien. med. Blätter, 1894, xvii, 653; Centralbl. f. Physiol., 1895–96, ix, 469.

[9] Traité clinique des maladies du cœur et de l'aorte. Paris, 1899, 3è éd., i, 395.

[10] Morgagni, J. B. De sedibus et causis morborum, etc., Venitiis, 1761. Book I, Letter IX, Art. 7. Ad quod ut redeam; perstringam paucis, quantum potero, quæ multa ac diu in cive meo Anastasio Poggio, gravi, proboque Sacerdote animadverti. Agebat is annum duodeseptuagesimum, subpingui habitu, et florido colore, præditus, cum primum comitiali morbo correptus est, qui summam pulsuum raritatem, itemque corporis perfrigerationem post se reliquit. Sed hæc intra horas septem victa est, nec, sæpius redeunte morbo, amplius rediit: illa usque perstitit. Prima epilepsia dolori successerat hypochondrii dexteri, per biliosas dejectiones soluto: cæteræ, quæ leviores erant, fere succedebant sensui cujusdam quasi fumi ad caput ascendentis ex hypochondriis quorum turgentia assidue ægro molesta erat, et facile ab assumptis, liquidis præfertim, augebatur.

Letter LXIV, Art. 5.

Mercator erat Pativii annos natus quatuor et sexaginta, quadrata statura, et obeso, non tamen nimium, corporis habitu. Is olim rheumati, et nervorum contractionibus cum esset obnoxius, Medicis auxiliis sanatus fuerat, ut quamvis pluribus, variis que negotiis assidue distineretur, valeret tamen ad eam usque ætatem quæ modo indicata est cum improviso ea acciderunt, unde vehementissimis animi affectibus terrore, timore, iraque deinde, et mæstitia corripiretur. Paucis post hæc diebus, quadam ingruente quasi vertigine, cecidit. Postridie autem motibus convulsivis cum insultu, epileptici simili, vexari cœpit. Is erat brevis, sed frequens, et ructibus fœtidis erumpentibus solvebatur, subsequente faciei interdum rubore, interdum pallore, sensu autem augustiæ faucium, et ventriculi perpetuo gravis. Erant pulsus eo tempore validi quidem, sed duri, et rari: alvus autem, et vesica perpauca redebant.

. . . Hæc menses perstitit circiter quatuor donec post brevem ambulationem, et scalarum ascendum, priores illi convulsivi insultus, rariores tamen, et breviores, invadere iterum cœperunt, et pulsuum raritatem reducere. Mensis tum erat December. A quo tempore usque ad Junii initium cum morbus vinci non posset, tunc ego consulendi causa accersitus, et ea quæ tibi hactenus descripsi, audivi, et ægrum qualem ex memorata Epistola cognoscere potes, inveni. Raritas præcipue pulsuum illa tanta, ut eorum numerus duabis circiter tertiis partibus minor esset quam oporteret, cum inculcabatur, tum a me quoque reperiebatur.